18080-005

NorthShore University HealthSystem

EVANSTON HOSPITAL DENTAL CENTER
MEDICAL/DENTAL HISTORY QUESTIONNAIRE FORM

18080-005 (05/2009)

Name_____ Date_____

Address_____ City _____State _____ Zip code_____

Home phone _____ Cell phone _____ Work phone_____

Birth date _____ Sex M F

Marital status: Single Married Divorced Occupation_____

Height_____ Weight_____ BP_____ Pulse_____

Closest relative_____Phone_____

If you are completing this form for another person, what is your relationship to that person? _____
_____

Referred by_____

MEDICAL HISTORY

1. Are you in good health? YES NO

2. Has there been any change in your general health within the past year? YES NO

3. My last physical examination was on _____

4. Are you under the care of a physician(s)? YES NO If yes, name of physician(s) and address(es):
_____
_____

5. Have you ever had any serious illness, operation, or been hospitalized in the past? If so, what was the illness or problem?
_____
_____
_____

6. List all medications including the doses that you are taking including over the counter medications.
_____
_____
_____
_____

7. Are you allergic to or have you had a reaction to any of the following?

Local anesthetics	YES	NO
Penicillin or other antibiotics	YES	NO
Sulfa drugs	YES	NO
Barbiturates, sedatives, or sleeping pills	YES	NO
Aspirin	YES	NO
Iodine	YES	NO
Codeine or other narcotics	YES	NO
Latex	YES	NO
Any metal/plastic (including jewelry)	YES	NO
Other	YES	NO

8. Do you have, or ever had, any of the following diseases or problems?

Heart disease	YES	NO
Congenital heart lesion	YES	NO
Rheumatic fever/Rheumatic heart disease	YES	NO
Heart murmur	YES	NO
Heart surgery	YES	NO
Heart valve repair or replacement	YES	NO
Swollen ankles/feet	YES	NO
Shortness of breath	YES	NO
Fainting or dizziness	YES	NO
Chest pain	YES	NO
Endocarditis	YES	NO
Stent placement (coronary, kidney, etc.)	YES	NO
Heart pacemaker	YES	NO
AICD (automatic implantable cardiac defibrillator)	YES	NO
Organ transplantation (heart, kidney, lung, bone, etc.)	YES	NO
Aneurysm repair	YES	NO
Stroke	YES	NO
Diabetes	YES	NO
Hypoglycemia	YES	NO
Kidney disease	YES	NO
High blood pressure	YES	NO
Low blood pressure	YES	NO
Hives or skin rash	YES	NO
Respiratory disease	YES	NO
Hay fever	YES	NO
Asthma	YES	NO
Use an inhaler?	YES	NO
COPD (chronic obstructive pulmonary disease)/Emphysema	YES	NO
Persistent cough or cough that produces blood	YES	NO
Tuberculosis	YES	NO
Splenectomy	YES	NO
Liver disease	YES	NO
Hepatitis – Type: A, B or C	YES	NO
Jaundice	YES	NO
Epilepsy/Seizure disorder	YES	NO
Stomach ulcer	YES	NO
Inflammatory Bowel Disease (Crohn's disease, Ulcerative colitis)	YES	NO
Arthritis/joint pain	YES	NO
Blood disease/disorder	YES	NO
Prolonged bleeding/abnormal bleeding	YES	NO
Hemophilia	YES	NO
Anemia	YES	NO

Sickle cell disease	YES	NO
G-6PD deficiency	YES	NO
Thyroid disease	YES	NO
Autoimmune disease	YES	NO
Rheumatoid arthritis	YES	NO
Problems of the immune system	YES	NO
HIV positive	YES	NO
AIDS	YES	NO
Persistent diarrhea or recent weight loss	YES	NO
Persistent swollen glands in neck	YES	NO
Sexually transmitted disease	YES	NO
Sinus problems	YES	NO
Tumors or growths	YES	NO
Cancer	YES	NO
Glaucoma	YES	NO
Nervousness	YES	NO
Mental illness	YES	NO
Depression	YES	NO
Bipolar disorder	YES	NO
Eating disorder	YES	NO
Alzheimer disease	YES	NO

9. Have you ever required a blood transfusion? YES NO

10. Have you ever had a joint replacement (hip, knee, shoulder, or ankle)? YES NO
    If yes, when?_____

11. Have you ever had chemotherapy? YES NO
    If yes, when and for what?_____

12. Have you ever had radiation treatment? YES NO
    If yes, to what part of your body and when?_____

13. Have you ever been treated with bisphosphonates such as Zometa, Aredia, Actonel, Fosamax, or Boniva? _____

14. Is there any other diseases, conditions, or problems with your health that we should know about?_____

15. Have you ever taken antibiotics before dental treatment in the past? YES NO
    If yes, what antibiotic?_____

16. Have you ever taken any of the following appetite suppressant drugs Fenfluramine(Pondimin), dexphenfluramine(Redux), phentermine(fen-phen)? YES NO

17. Are you on any steroid medications or have you ever been on steroid medications? YES NO
    If yes, what medication and when?_____
    _____

18. Is your diet: low in sugar intake or medium in sugar intake or high in sugar intake?

19. Do you drink alcohol? YES NO If yes, how many drinks per week _____

20. Have you ever smoked cigarettes? YES NO
    If yes, how many packs per day and for how many years?_____
    Year quit_____
    Have you ever smoked cigars? YES NO
    If yes, how many and for how many years?_____
    Have you ever smoked a pipe? YES NO
    Do you chew tobacco? YES NO

21. Do you use recreational drugs? YES NO Type/frequency_____

22. Do you have a family history (consider grandparents, parents, siblings) of: (circle)

cancer	diabetes	heart disease	high blood pressure	seizures
stroke	kidney disease	asthma	bleeding disorders	liver disease

WOMEN ONLY

23. Are you pregnant? YES NO

24. Do you anticipate becoming pregnant? YES NO

25. Do you have any problems associated with your menstrual period? YES NO

26. Are you nursing? YES NO

27. Are you taking birth control pills? YES NO

DENTAL HISTORY

1. Do you have regular non-emergency dental care? YES NO

2. Have you ever chipped or injured any of your teeth? YES NO

3. Are your teeth sensitive to hot or cold or sweets? YES NO

4. Have you ever had teeth treated with root canals? YES NO

5. Do you have bleeding gums, bad taste or mouth odor? YES NO

6. Have you ever had periodontal (gum) treatment? YES NO

7. Does food wedge in between your teeth? YES NO

8. Do you get “gum boils”? YES NO

9. Do you get frequent canker sores or cold sores in your mouth or on your lips? YES NO

10. Does your mouth frequently become dry? YES NO

11. Do you have or ever had a thumb or finger sucking habit? YES NO

12. Do you frequently press your tongue against your teeth? YES NO

13. Do you have a mouth breathing habit, snoring or difficulty in breathing? YES NO

14. Are you aware of clenching or grinding your teeth while awake or while asleep? YES NO
15. Do you have clicking or locking of your jaws? YES NO
16. Have you ever been treated for TMJ problems? YES NO
17. Have you ever had difficulty in chewing or jaw opening? YES NO
18. Do you have a history of extra teeth (supernumerary) or missing teeth? YES NO
19. Have you ever had orthodontic treatment? YES NO
20. Are you concerned about crooked teeth, protruding teeth or spaces between teeth? YES NO
21. Are you aware or concerned about under or over developed jaw? YES NO
22. Have you ever had jaw surgery? YES NO
23. Are you aware of any wisdom teeth problems? YES NO
24. Have you had any serious trouble associated with any previous dental treatment? YES NO
25. Have you ever had abnormal bleeding with dental "cleanings", extractions, surgery or trauma? YES NO
26. Do you have any removable dental appliances? YES NO
27. Are you happy with your teeth? YES NO

What is your primary concern—Why are you here? _____
_____

Date of most recent dental examination? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?_____
_____
_____

I certify that I have read and understand the above questions. I acknowledge that my questions, if any, about the above inquires have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of patient or guardian Date

FOR COMPLETION BY THE DENTIST

Comments or significant findings from patient interview concerning medical/dental history:_____
_____
_____
_____
_____

Dental management considerations: _____
_____
_____
_____

Signature of Dentist_____ Date: _____

Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____